Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Randall, a prisoner at HMP Birmingham, on 11 January 2025

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Christopher Randall died from mixed drug intoxication, including use of psychoactive substances, on 11 January 2025, at HMP Birmingham. He was 33 years old. I offer my condolences to Mr Randall's family and friends.

Mr Randall was withdrawing from drugs when he arrived at Birmingham on 6 January. He should have been checked by healthcare staff during the day and night but the investigation found that the night checks were not carried out properly. Had they been on the night of 10/11 January, it is possible that healthcare staff would have identified that Mr Randall was unconscious and he could have received medical intervention sooner.

The clinical reviewer found that Mr Randall's care was not of the required standard and was not equivalent to that which he could have expected to receive in the community.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **January 2026**

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Summary

Events

1. On 6 January 2025, Mr Christopher Randall was remanded in prison, charged with theft and assault, and sent to HMP Birmingham. It was not his first time in prison.

2. Mr Randall tested positive for cocaine, benzodiazepines, opiates and cannabinoids when he arrived at Birmingham. Healthcare staff from Birmingham Recovery Team (BRT, the prison's substance misuse team) placed him on a detoxification programme and he was subject to monitoring for his first five days, which should have consisted of daily clinical observations and nightly welfare checks. Staff conducting the night checks were supposed to obtain a response or observe breathing or movement.

3. During the nights of 8/9 and 9/10 January, the nurse responsible for checking Mr Randall recorded that she could not see him because there was a towel draped over the end of the bed. She recorded that he was in bed and "may be asleep".

4. At 1.12am on 11 January, the nurse went to Mr Randall's cell to carry out the night check. Again, she recorded that she could not see Mr Randall due to the towel, that he was in bed and "may be asleep". She recorded that "they [the cell occupants] were not disturbed due to the time". At interview, she said that she did not want to wake prisoners during the night.

5. At around 2.10am, when he got up to use the toilet, Mr Randall's cellmate saw that Mr Randall was on his bed with no covers over him. When he went to put a cover on him, he realised Mr Randall was cold and not breathing. He alerted staff who attended and started CPR. Ambulance paramedics arrived and continued with the resuscitation attempt. However, at 3.06am, they pronounced life extinct.

6. After Mr Randall's death, his cellmate told staff that they had been using drugs in their cell. The post-mortem report concluded that Mr Randall died from mixed drug intoxication which included recent use of psychoactive substances (PS).

Findings

7. The last report by HM Inspectorate of Prisons following their inspection of Birmingham in early 2023 noted that some overnight checks of prisoners on the drug recovery wing were not completed correctly. We found that this remained an issue in this investigation and that the same issue occurred in the death of another prisoner two days before Mr Randall's death. The Head of Healthcare has since introduced a weekly audit to check that BRT nurses are completing day and night checks correctly.

8. The pathologist who carried out Mr Randall's post-mortem examination said that there were signs that Mr Randall had been deeply unconscious in the time leading to his death. It is possible that had the nurse carried out a proper check of him at 1.12am, she would have identified he was unconscious, and he would have received medical intervention sooner. The Head of Healthcare has taken steps to address the quality of night checks with the nurse concerned.

9. The clinical reviewer concluded that the clinical care Mr Randall received at Birmingham was not equivalent to that which he could have expected to receive in the community.

10. Mr Randall received appropriate support and harm minimisation advice from BRT. In terms of drugs entering the prison, we are satisfied that Birmingham is taking appropriate steps to tackle the problem.

11. We make no recommendations.

The Investigation Process

12. HMPPS notified us of Mr Randall's death on 13 January 2025.

13. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

14. The investigator visited Birmingham on 22 January 2025. She obtained copies of relevant extracts from Mr Randall's prison and medical records.

15. The investigator interviewed six members of staff and Mr Randall's cellmate at Birmingham on 22 January and 13 February.

16. NHS England commissioned an independent clinical reviewer to review Mr Randall's clinical care at the prison and she conducted joint interviews with the investigator.

17. We informed HM Coroner for Birmingham and Solihull of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

18. The Ombudsman's office contacted Mr Randall's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She wanted to know the details concerning his presentation and mood when in prison, the events leading to his death, including when he was last seen alive. We have addressed these issues in this report and the clinical review.

19. The investigation was suspended from 26 March until 22 August while we waited for a copy of the post-mortem report.

20. We shared our initial report with HMPPS and the prison's healthcare provider, Birmingham and Solihull Mental Health NHS Foundation Trust. HMPPS pointed out a minor factual inaccuracy which has been corrected in this report.

21. We sent a copy of our initial report to Mr Randall's mother. She did not notify us of any factual inaccuracies.

Background Information

HMP Birmingham

22. HMP Birmingham is a category B adult male reception prison. It is managed by HMPPS. Birmingham and Solihull Mental Health NHS Foundation Trust provides healthcare services. The Birmingham Recovery Team (BRT) runs the substance misuse service.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Birmingham was in January and February 2023. Inspectors reported drug supply was far lower than at their last inspection in 2018, which may have been due to the significant investment in security arrangements to prevent the ingress of drugs and other contraband. However, there was no random mandatory drug testing, which meant leaders were not fully aware of the drugs being used in the prison or the extent of the problem.

24. Inspectors also noted concerns that some night observations on prisoners on the drug recovery wing were not performed correctly. In one case, the observation panel was covered and others were not fully observed.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year ending 30 June 2024, the IMB reported that the use of the X-ray body scanner had significantly reduced the number of drugs and other illicit items being brought into the prison, but the prison continued to be troubled by drones transporting illicit items into the establishment.

Previous deaths at HMP Birmingham

26. Mr Randall was the 18th prisoner to die at HMP Birmingham since January 2022. Of the previous deaths, ten were from natural causes, three were self-inflicted, three were drug related (one of these deaths occurred two days before Mr Randall died), and one was a homicide. Up to the end of October 2025, there have been four further deaths, three from natural causes and one where the cause of death is currently unknown.

27. Our investigation into the drug-related death that occurred two days before Mr Randall's also found that the prisoner had failed to receive several doses of his medication that had been prescribed to help with his alcohol withdrawal symptoms.

Psychoactive Substances

28. The term psychoactive substances (PS) is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids (including nitazene) are substances that mimic the effects of traditional

controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.

29. PS can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of these substances can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

Key Events

30. On 6 January 2025, Mr Christopher Randall was remanded in prison, charged with theft and assault, and sent to HMP Birmingham. He arrived from court with a suicide and self-harm (SASH) warning, which said that Mr Randall had numerous self-harm scars on his arms and had tried to hang himself on 4 January prior to his arrest. A custodial manager (CM) from the Safer Custody Team conducted a welfare interview with him. Mr Randall said he had punched a wall when he was at court as he had been frustrated about how long the court process was taking and he wanted to get to the prison and settle into his cell. He said that he did not have any thoughts of suicide or self-harm. The CM considered that suicide and self-harm monitoring (known as ACCT) was not necessary.

31. A nurse completed Mr Randall's reception healthcare screen. She noted that Mr Randall had a history of anxiety and depression, PTSD, bipolar disorder and borderline personality disorder. Mr Randall said he was withdrawing from alcohol and drugs. He tested positive for cocaine, benzodiazepines, opiates and cannabinoids. He said that he was happy to be in prison to get the support he needed.

32. Mr Randall was allocated to work with specialists in the Birmingham Recovery Team (BRT - the prison's substance misuse service). As part of the induction reception process, a nurse completed a check at 2.09am and noted that Mr Randall was alert and polite in their interaction.

33. The next morning, a GP prescribed Mr Randall with medication for back pain and depression.

34. An officer completed the first key worker session with Mr Randall. He said he wanted to detox from drugs and alcohol and had no thoughts of self-harm.

35. A BRT worker completed Mr Randall's substance use assessment. Mr Randall said he smoked drugs daily. Mr Randall was allocated a cell in the Integrated Drug Treatment Strategy (IDTS) wing to begin his detoxification. He was prescribed methadone to treat his withdrawal from opiates and diazepam for his alcohol detoxification. Prisoners on the IDTS receive welfare checks during their first five days. BRT nurses complete clinical observations during the day and a welfare check at night.

36. A key worker for psychosocial support also met Mr Randall that day. Mr Randall discussed his alcohol and drug use and accepted the support to address these.

37. Mr Randall was in a double cell with a cellmate. Mr Randall occupied the lower bunk bed. At interview, Mr Randall's cellmate said for most of the day they were locked in the cell. They ate their meals in the cell, talked and watched television.

38. On 7 January at 12.18pm, a healthcare assistant recorded that she had completed her check and had spoken to Mr Randall. She noted that he presented well and was alert and coherent. A nurse carried out the night check and recorded at 11.50pm that Mr Randall was asleep and she had noted movement when she switched on the cell light. An officer recorded that she had completed well-being checks at 10.00pm, 12.20am and 6.00am on 8 January and had no concerns.

39. The healthcare assistant recorded at 11.02am that she had spoken to Mr Randall and checked his observations and had no concerns.

40. Nurse A carried out the night check of Mr Randall. She recorded at 12.25am on 9 January that she could not see either occupant of the cell as a towel was draped over the end of the bed. She recorded, “He [Mr Randall] was in bed and may be asleep. They were not disturbed due to the time.” She also recorded, “The night officer was informed.” At interview, she said that she did not like to wake prisoners during the night and so she would turn the light on and off to see if there was any response and if not, she would tell an officer. There was no evidence that she told an officer.

41. Nurse B completed the day check on 9 January and recorded at 10.45am that Mr Randall appeared well, was happy with his treatment and had no concerns.

42. Later that morning, Mr Randall told a nurse that he had not been collecting his diazepam as he did not know where the medications hatch was on the IDTS wing. He had missed four doses over two days. The nurse sent a message to BRT nurses who extended the diazepam course from five days to seven days.

43. Nurse A carried out the night check. At 11.45pm, she again recorded that she could not see Mr Randall, that he was in bed and “may be asleep”, and that, “the officer was informed". There was no record that she told an officer.

44. On 10 January, Nurse C completed the day checks of Mr Randall. She recorded at 10.08am that she had spoken to Mr Randall, that he was alert and orientated, and she had no concerns.

Events of 11 January 2025

45. The investigator watched CCTV footage and body worn video camera (BWVC) footage from 11 January. She also obtained information from West Midlands Ambulance Service.

46. Mr Randall’s cellmate told us that they were both locked into their cell from around 4.30pm. He said he got out of his bed at approximately 10.00pm to use the toilet and saw Mr Randall asleep.

47. CCTV shows that at 1.12am, Nurse A completed her night check. She looked through the observation panel into Mr Randall’s cell. She recorded, as she had for the previous two nights, that she could not see Mr Randall due to the towel draped over the end of the bed, that he was in bed and “may be asleep” and that she did not disturb them and told an officer. However, CCTV shows that she did not speak to the accompanying officer. She continued walking along the landing to the next person on her check list.

48. Mr Randall’s cellmate told us that at approximately 2.10am, he got out of bed to use the toilet. He saw Mr Randall lying on his bed with no covers. He thought Mr Randall was in the same position as when he had last seen him. As it was a cold night, he went to put a cover on Mr Randall when he realised he was cold and not breathing. He pressed the emergency cell bell and banged on the cell door to alert staff. Officer A responded. In his statement he said that he immediately radioed a

code blue (a medical emergency code used when a prisoner is unconscious that alerts healthcare staff and tells the control room to call an ambulance immediately). Officer B was the first person to join Officer A and they opened the cell door. Officer B radioed a code blue again. They moved Mr Randall from the bed onto the floor as they checked him. In Officer B's statement he said he checked for a pulse but there was none, and Mr Randall was very cold to touch. They began CPR as more staff arrived. Staff asked Mr Randall's cellmate to leave the cell and he was taken to a cell on the healthcare win.

49. Nurse D was the first nurse to arrive at the cell. She assisted with CPR.

50. After the emergency radio code blue was called, an officer went to Nurse A and told her she was needed at the emergency response. When she arrived, she saw officers completing chest compressions. She helped set up the defibrillator. Staff used the defibrillator and one shock was delivered.

51. The West Midlands Ambulance Service records noted that the emergency telephone call was received at 2.12am. Ambulance paramedics arrived at Mr Randall's cell at 2.21am. The ambulance paramedics took over the resuscitation attempt. At 3.06am, the senior paramedic declared life extinct.

52. After Mr Randall's death, his cellmate told a prison manager that they had been smoking illicit substances in their cell and had crashed out.

Contact with Mr Randall's family

53. The prison appointed the Head of Business Assurance as the family liaison officer and a prison chaplain as her deputy. They both visited Mr Randall's mother to break the news of his death and offer support.

54. The prison made a contribution towards the cost of Mr Randall's funeral, in line with national guidelines.

Support for prisoners and staff

55. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

56. After Mr Randall's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

57. The prison posted notices informing other prisoners of Mr Randall's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or

self-harm in case they had been adversely affected by Mr Randall's death. Listeners were sent to the wing to offer support.

Post-mortem report

58. The post-mortem report concluded that Mr Randall's cause of death was mixed drug intoxication (MDMB-4en-PINACA, methadone, diazepam and cocaine). Toxicology tests showed that Mr Randall had used MDMB-4en-PINACA, a synthetic cannabinoid, at some point prior to death. The pathologist noted that synthetic cannabinoids have been associated with fatal cardiac arrhythmias (irregular heartbeat). Methadone and diazepam were detected at therapeutic levels. Cocaine was also detected but at a low concentration which indicated less recent use. The pathologist noted that the use of methadone and diazepam (which have central nervous depressant effects) alongside cocaine (a stimulant) was an unsafe situation with unpredictable and even fatal outcomes.

59. The pathologist noted that Mr Randall had thick mucus in his airway that suggested he had been deeply unconscious in the time leading to his death.

Findings

Cause of death

60. Toxicology tests showed that Mr Randall had used PS before he died and his cellmate admitted that they had both smoked drugs that evening. Mr Randall had a long history of drug use and was under the care of the prison's substance misuse team, BRT, who had provided harm minimisation advice. We consider that Mr Randall had been warned of, and understood, the dangers of using drugs.

Drug strategy

61. The prison reported a noticeable rise in illicit drug use in January 2025. Of particular concern were the two drug-related deaths two days apart. The drug strategy lead at Birmingham told us that the prison used various methods to restrict the supply of drugs. Drug detection dogs were used to search the perimeter and grounds, while enhanced gate procedures had been introduced for all staff entering the prison. To specifically reduce the risk of PS entering the prison, all legal visits had been made paperless, and incoming packages were subject to X-ray screening. Additionally, letters were photocopied before being delivered to the wings.

62. Illicit drugs remain a widespread issue across the prison estate. Birmingham has taken steps to raise awareness among staff and prisoners and to reduce the supply of drugs. We were told that prisoners on arrival in reception are offered an amnesty to relinquish any illicit items before the formal searches without consequence. More prisoners have the opportunity to engage in suitable work, activity and treatment to reduce demand (the idea being that engaged prisoners are less likely to use drugs). Prisoners are also encouraged to engage in peer led drug and alcohol groups for support.

63. We understand that a major change is planned from October 2025, when the prison will replace all current vapes with tamper-proof versions to prevent them being modified for drug use.

64. We are satisfied that Birmingham has a comprehensive strategy for reducing demand and supply of illicit drugs.

Clinical findings

65. The clinical reviewer concluded that the clinical care Mr Randall received at Birmingham was not equivalent to that which he could have expected to receive in the community. She found that the night checks were not completed properly for three consecutive nights.

Night checks

66. The local policy on completion of night checks is outlined in the Standard Operating Procedure (SOP) BRT 1.2. The SOP says that night checks should be completed by looking through the cell door and checking for breathing/ movement and/or

thumbs up and confirmation. The SOP does not include instructions on waking prisoners at night if it has not been possible to detect movement.

67. The BRT clinical team manager told us that she would expect nurses to check for signs of life by switching on the cell light or using a torch to check for movement. If there was any obstruction, nurses were expected to ask the night officer to unlock the cell and if this was refused, the nurse should record the name of the officer and escalate to a manager.

68. In the most recent HMIP inspection in 2023, inspectors noted that healthcare staff were not always completing night checks correctly. In response, the BRT clinical manager issued a reminder email to staff which said that a review of medical notes for the night checks had highlighted an issue as staff had a duty of care to ensure the patient was visible. Staff were expected to see movement to confirm a patient was breathing and to note that a nurse was "unable to see" was not acceptable. Staff were asked to complete detailed documentation for confirmation of breathing. The email attached the SOP BRT 1.2 for reference.

69. Nurse A did not complete proper night checks on Mr Randall as she noted that she could not see him. She did not observe breathing and did not seek any response from him. Although she noted that she had informed the night officer, no other details were recorded and she did not escalate to a manager.

70. Nurse A went to Mr Randall's cell at 1.12am. Had she carried out a proper check, she might have identified that Mr Randall was unconscious, and he could have received medical intervention sooner. (The post-mortem noted that he was likely to have been deeply unconscious in the period leading to his death.) It was another hour before his cellmate realised that Mr Randall was unresponsive.

71. At interview, Nurse A said she was not aware of the SOP BRT 1.2, despite working for BRT for over 20 years. She said her practice was not to disturb sleeping prisoners but she accepted that she was not following the required procedures and would do so going forward.

72. The BRT clinical team manager told us that she had started a weekly audit and now checked at least one clinical record from all BRT nurses to ensure that the templates for day and night checks were fully completed and documented in the clinical notes. She had also taken action to address the issues around Nurse A's completion of night checks. As action has already been taken to address these issues, we make no recommendations in this report. However, the clinical reviewer has made recommendations which the Head of Healthcare will wish to address.

Alcohol withdrawal medication

73. The clinical reviewer found that Mr Randall was appropriately prescribed medication to support him with the management of his alcohol withdrawal symptoms. However, he missed four doses between 7 and 9 January because he did not know where the medications hatch was after he was moved to the IDTS wing. The missed doses were not identified until Mr Randall told a nurse.

74. The clinical reviewer has made a recommendation on this which the Head of Healthcare will wish to address. We made a recommendation on a similar issue

following our investigation into the drug related death that occurred two days before Mr Randall's death. The Head of Healthcare accepted the recommendation and said that templates had been amended to remind staff to check medication compliance and discuss any non-compliance with the individual concerned.

Inquest

75. At the inquest, held from 1 to 5 December 2025, the jury concluded that Mr Randall's death was drug related.

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